MEDICAL PRACTICE

Contemporary Themes

Psychiatry in the Soviet Union

J. K. WING

British Medical Journal, 1974, 1, 433-436

Summary

The services for chronically handicapped people with psychiatric disorders in the Soviet Union are described. The system is based upon a network of community units, each of which includes a day centre, a follow-up clinic, and a sheltered workshop. British services could profitably learn from the experience of these units. The diagnostic system used by many Soviet psychiatrists is different from that incorporated in the International Classification of Diseases. In particular, the term "schizophrenia" is used to describe conditions which British psychiatrists would label in other ways.

This clinical difference partly explains the different concept of "criminal responsibility," but another large component of the difference is political rather than medical. There are also variations from British practice in certain juridical procedures. These differences together make Soviet psychiatric practice in the case of political dissenters unacceptable to most British psychiatrists. It is too soon to say that frank discussions of these matters could not lead to improvement. British and Soviet psychiatrists still have something to learn from each other.

Introduction

I have visited the Soviet Union on four occasions, each time for a different purpose. A brief account of these experiences, particularly those concerned with problems of diagnosis, provision of services, and forensic psychiatry, might be found helpful by those interested in recent controversies between Soviet and British psychiatrists. I have tried to make my account as factual and objective as possible.

Institute of Psychiatry, London
J. K. WING, M.D., Professor of Social Psychiatry

Soviet Psychiatric Services

Social psychiatry has long been part of general psychiatry in the Soviet Union.[1-3] Even in prerevolutionary times there was an early form of district service, with case registration and an emphasis on after-care. The social security programme introduced in Lenin's time provided pensions for the disabled and laid great stress on help to achieve full working capacity. During the 1920s and 1930s a system of extramural psychiatry was set up based on a network of dispensaries, day hospitals, and workshops and on services for social and industrial resettlement, such as rehabilitation units, training centres, vocational guidance units, and prophylactic workshops in the factories themselves.

The system of dispensary care is now extremely well developed in Moscow and Leningrad and contains some useful ideas for British psychiatry, particularly in the field of rehabilitation and community care.[4 5] Primary consultation takes place at a polyclinic (or health clinic), which is staffed mainly by general physicians, paediatricians, gynaecologists, and surgeons. There are also "neuropathologists," dermatologists, and other specialists. A patient with psychiatric disorder may be seen first by a general physician and then referred to the "neuropathologist." Only after this stage, assuming the condition still requires treatment, is the patient referred to the dispensary. There is, however, an emergency or first-aid system (administered by the city psychiatrist), which operates when the polyclinics are closed.

The dispensaries serve given catchment areas; for example, the Moscow No. 8 dispensary serves two rayons with a total population of about 500,000. There is one dispensary psychiatrist to 33,000 population. Each psychiatrist works closely with a nurse (who is present during examinations). The doctor works a six-hour basic day, four hours of which are spent in the

dispensary and two hours visiting patients' homes and places of work and engaging in health education and consultation. Each doctor sees about 16-20 patients in the dispensary each day, two or three of them first referrals from a polyclinic. There are various schedules of visiting, ranging from patients who need to be seen twice a week to those who need to be seen only once a year. If a patient does not keep an appointment, he or she is telephoned or visited at home by the doctor or nurse.

CLOSE LIAISON

Though the psychiatric hospital system is administratively distinct, patients from a given district are always admitted to the same hospital and the dispensary and hospital doctors are in close contact. In Leningrad, for example, no patient has more than two doctors, one in the hospital and one in the dispensary. Detailed clinical summaries, containing specified information (for example, the maximum dose of drugs used, the recommended therapeutic and maintenance doses, etc.), are routinely supplied to the dispensary within a few days of discharge, and the patient is required to attend at the dispensary within five days of discharge. Again, there is a home visit or telephone call in the case of default.

There are many specialists at the dispensaries, notably for alcoholism, which accounts for 1 in 7 of all referrals. There is very little narcotic addiction. Other specialists deal with children, epilepsy, neurological disorders, mental retardation, etc. Special departments at the dispensary deal with various types of "physiotherapy" (including electronarcosis, hydrotherapy, and many techniques which are uncommon in the U.K.: massage, ultraviolet light, electrical stimulation of muscles and skin, etc.), speech therapy, individual psychotherapy, and group and "collective" psychotherapy. The last is concerned with patients in relatively large groups (what we would call a patient-staff meeting). A substantial department is responsible for patients with mental retardation; teachers with special training, known as "defectologists," figure prominently, as well as speech therapists on a most generous scale.

Each dispensary has a day hospital and one or more workshops. (The latter should be distinguished from the similar facilities provided by hospitals, which are used only for the rehabilitation of inpatients.) All patients must be able to travel by public transport (there is a home occupation programme for some of those who cannot). Patients stay in the day hospitals for up to six weeks mainly during phases of "decompensation" which do not require inpatient treatment.

The three workshops attached to the Moscow district dispensary (serving 400,000 population in Leningrad) were particularly well developed, providing among them some 180 places (in addition to 100 day hospital places). The work included making cardboard trays (cutting cardboard with a large guillotine, folding it, stapling corners, stacking, and packing), making plastic bags and boxes (throughout all the stages, beginning with the liquid material supplied by the factory), assembly of electrical and other fittings, sewing pinafores by machine and making Cellophane wrappers for sausages. Each of these tasks was organized by stages within one room, moving progressively from one small group of patients to another until finally completed. Each of the three workshops had its own doctor, a nurse, two instructors, a foreman, a bookkeeper, and one healthy worker. Some tasks are undertaken particularly by the the mentally retarded and they have their own rooms. Nevertheless, the commonest diagnosis is schizophrenia. The workshops are financed out of the "profit" made from selling the products, which is very considerable because national and local taxes are not payable, though the market price is charged for the goods. The new building housing the Moscow district dispensary was actually paid for out of these "profits."

The patients in the workshops get an invalidity pension (depending on the severity and chronicity of the condition), a salary depending on their output of work, free food during the day, and free excursions, etc. They do not pay tax on their wages. Their average budget, counting everything, is said not to be greatly different from that of non-handicapped workers. It is not entirely clear how long handicapped people continue in these workshops, but probably not for more than a year or two.

TYPES OF HOSPITALS

There are 2·0-2·5 beds per 1,000 population in psychiatric hospitals serving the acutely ill. The average length of stay is two months. In addition, there are sanatoria or nursing homes for short-term convalescence. For example, the Kashchenko Hospital in Leningrad has 100 beds in a sanatorium in a village outside the city, and the dispensary we visited had the right to send 20 patients there each month. Nevertheless, the length of stay is limited to one month. There are no "hostels" in the British sense and handicapped patients without families are mainly in long-stay psychiatric hospitals. There are two mental hospitals for Leningrad patients in the country outside the city, for the longest-stay patients. Such hospitals have from 100 to 600 beds. It is now recognized that the open-door system should apply to these hospitals too and considerable improvements are being carried out. They usually have attached farms and workshops in the neighbourhood belonging to collective farms. The first U.S. mission on mental health visited a rural hospital and described it in their report.[6] Family care has not continued to develop since the war.

As well as the district psychiatrists who have consulting functions in local factories, a system is now starting of factory psychiatrists in very large plants (for example, car factories), whose function is to care for the mental health of workers. A great deal of attention is given to the optimal placement in work of people who have been psychiatrically ill. Many factories have special workshops for handicapped people—for example, a sewing machine factory in the neighbourhood of No. 8 dispensary in Moscow has 300 handicapped people in such a shop, 30% of them psychiatric, as well as providing sheltered conditions for other handicapped people within the open workshops. The standard of work required is, of course, very much higher in the open factories than in the sheltered workshops (though these have a much higher standard than our day centres). For example, such workers need to be members of a trade union; they need sickness certificates if they wish to stay away from work; etc. In addition, there are special factories equivalent to those of the British Remploy organization, some of them with homes attached. Since these come under a different ministry it was difficult to obtain information about numbers.

Each dispensary has its own medical records department, which is highly organized to show which patients have appointments, who arrived and who did not, who needs to be visited at home, and so on. A summary card is completed for each patient at the time of admission to dispensary care and at the time of discharge. This goes to the Serbsky Institute.

The staffing ratios for these dispensaries are most generous by our standards. The dispensary we visited in Leningrad, serving a population of 400,000 people, had a total staff of 160, including 27 doctors, 56 nurses, and 50 occupational supervisors. Ten of these doctors were district psychiatrists, responsible for subareas of about 40,000 people each (and paid overtime, to the extent that they worked longer hours to make up the norm of one to 33,000), dealing only with outpatient supervision, follow-up, and health education. Doctors tend to specialize rather narrowly. Those concerned with functional psychosis, for example, may know rather little about neurosis or about dementia. Doctors in charge of dispensaries tended to describe their activities "by numbers," as though this was how they trained their staff in a system which would cover most routine situations. There did not seem to be much necessity to exercise independent judgement, hence the categories determining how

often the patient should be seen. My impression was that it is unusual to depart from the routine of follow-up or treatment laid down, that major decisions (for example, moving from one category to another) are referred to a commission and that there is a routine procedure for almost every occasion.

PROS AND CONS

My conclusion was that the dispensary system—at least as it functions in Moscow and Leningrad—contains many interesting features which would repay study by British psychiatrists. It is a very medically oriented service, carrying out many of the functions of our social service departments. There is no doubt that provision on an equivalent scale in the U.K. would relieve many of the problems now arising from the lack of local authority provision.

A word of warning, however, is in order. The very thoroughness of the service must carry a certain disadvantage. It would require a deeper knowledge of Russian life and custom than I possess to assess how far a certain gentle but insistent paternalism and over-protectiveness is characteristic throughout the whole society. It is plainly evident in attitudes to the mentally ill and retarded. In many cases it brings good results; probably the more severe the handicap the more satisfactory the system. I tried to discover whether a patient not under certificate is free to leave hospital "against advice," but it seemed very difficult for my informants to envisage such a case. After a great deal of questioning they did finally say that it would be possible but they could not recall it happening.

Many studies have been made of the insidious effects of "institutionalism"; the inmate gradually comes to accept the way of life of the institution, even though this means adopting attitudes and personal habits inimical to ordinary life outside. Institutionalism is often unavoidable but sometimes it is itself the only handicap and in such cases it is clearly harmful. A very detailed and thorough organization of after-care services might contain the seeds of the same disadvantage. Nevertheless, I think that we have a very long way to go before we run any similar risk of providing too all-embracing a service.

Diagnosis of Schizophrenia

The figure given for the prevalence of schizophrenia in Moscow, 5-7 per 1,000 population, is remarkably high: most U.K. studies suggest 3-4 per 1,000. The difference may be due partly to the very comprehensive knowledge that Russian psychiatrists obviously have of which people in the population are, or have been, suffering from schizophrenia, but a more likely explanation is that the diagnosis is more liberally made than in the U.K. It is accepted that there is a difference in this respect even between Moscow and other parts of the Soviet Union. The "Snezhnevsky school" of diagnosis is mainly responsible. Professor Snezhnevsky has enumerated several sub-classes of schizophrenia (a description of which exists in English) and one in particular (the sluggish variety) seems to include cases which American psychiatrists would diagnose as latent, pseudoneurotic, or pseudopsychopathic schizophrenia.

Volume 1 of the *International Pilot Study of Schizophrenia*, recently published,[7] confirms that American and Russian psychiatrists do tend to include a wider variety of conditions (as well as the large central group of cases which are recognized all over the world) under the label of schizophrenia than is customary elsewhere. Several psychiatrists are interested in the possibility of making the process of diagnosis more standard. A system of recording the various syndromes present at each stage of a patient's illness has been developed and is used routinely by all the psychiatrists in one particular district of Moscow, the results being recorded in the register system.[8]

Forensic Problems

I am not an expert on forensic problems and I do not have a fluent grasp of Russian. Both of these disadvantages detract from my competence to comment on recent controversies in this field, but, since I have had the opportunity of asking about certain well-known "cases," it may be useful if I describe my reactions. I have dealt with these matters in more detail elsewhere.[9 10]

There are three main conceptual differences to take into account. In the first place, there is nothing in our criminal law equivalent to the Soviet category of crimes against the state. Many of the people whose cases have been publicized have not committeed crimes according to our laws. (They often dispute that they have offended against Soviet law either.) For example, those convicted of the offence of falsely slandering the Soviet state by raising banners in Red Square bearing slogans such as "Long live free and independent Czechoslovakia," were sentenced to between three and five years' prison or exile in labour camps. The seriousness with which such actions are viewed is quite outside our experience but it is a fact of life in the Soviet Union. Perhaps treason during war-time is the closest analogy we can make. This difference is basically political.

In the second place, as we have already seen, the concept of mental illness, particularly of schizophrenia, is a good deal wider than in the U.K., including quite a lot of what we would call personality disorder. None of the people whose case histories I have heard were suffering from schizophrenia in the sense of the florid central syndrome recognized by psychiatrists everywhere. There are two main groups: one composed of people who had been admitted to mental hospitals long before they had become political dissenters (though not for what I would call "schizophrenia"); the other comprising people who have developed complex economic and social theories which they put forward as alternatives to currently orthodox Marxism. In this second group the diagnosis depends mainly upon an appraisal of the individual's personality, together with the detection of subtle abnormalities in emotional and cognitive processes (see the letter from 21 Soviet psychiatrists published in *The Guardian* of 29 September 1973). Most British psychiatrists would probably not make a diagnosis of schizophrenia (or of any kind of mental illness) in such cases.

The third conceptual problem concerns "responsibility." This is the most difficult one for the British psychiatrist to comment on since it means trying to answer a ludicrous non-question: should a person who is not severely mentally ill by our standards be regarded as responsible for an action which we would not regard as a crime? Assuming for the moment that the Soviet psychiatrists have made their diagnosis in good faith, the question looks quite different to them: is a person who is suffering from a slowly developing form of schizophrenia responsible for an action which is likely to land him, at the very least, in a labour camp for three years? The Soviet doctor claims that he is acting humanely and that, in essence, the part he plays is no different from that of the American psychiatrists who saved Ezra Pound from execution.

POLITICAL DISSENTERS

According to material published in the West,[11 12] some two dozen people who have committed acts of political dissent are known to have been sent to mental hospitals.* The large proportion of dissenters are sent to prison or to labour camps. Doubt has been cast on the motivation of the psychiatrists involved in the trials of political dissenters and it has been said that they make deliberately false diagnoses. This question of bad faith is a difficult one to determine for someone who does not speak Russian and who therefore cannot personally know any of the people concerned. Soviet practice in the cases I have some

*There may, of course, be others unknown in the West.

knowledge of would be quite unacceptable here but this would be true even if the psychiatrists concerned were acting in good faith.

Of the three types of conceptual difference that I have mentioned, the first, which is political, is by far the most important. It completely alters the value attached to the others. The second (the concept of mental illness) is much more amenable to discussion, and so are some aspects of the third (the concept of responsibility).

Another area of concern where some practical advance might be made is procedural. Someone who, by our standards, is perfectly capable of conducting a defence, may be prevented from contacting his relatives during the course of the investigation, which may be six months or more, denied access to a defence lawyer, and kept out of court at the time of trial. Moreover, the court need not necessarily see the accused person at all if the written recommendation of a commission of psychiatrists is accepted. Needless to say, the accused person's own wishes are not consulted when deciding upon a recommendation on non-imputability by reason of mental illness.

My personal view is that, so long as our differences on these issues can be frankly acknowledged and discussed, communications between British and Soviet psychiatrists should continue. Doctors are not likely to bring about much change in the political system, nor should they expect to do so, but they can attempt to influence each other's practice in their own professional sphere. Representations about individual cases may be more effective if stated in these terms.

The other thing that we can do, as I suggested in my paper at the recent conference in Yerevan, is to consider these issues in their international context. Complaints of malpractice have been made about medical services in several parts of the world, notably the United States and the Soviet Union, but our own country has not been immune from criticism. The initiative of the Royal College of Psychiatrists in suggesting a commission of inquiry to be set up by a number of national associations is therefore to be welcomed. This group would be concerned with the detailed investigation of individual cases, during the course of which there would inevitably be much discussion of ethical principles and of medicolegal procedures. I very much hope that such a body will be established, with active co-operation from the two largest national associations, as well as from those in Western Europe.

References

1 Galach'yan, A. G., in *Psychiatry in the Communist World*, ed. by A. Kiev. New York, Science House, 1968.
2 Melehov, D. E., *Social Psychiatry*, 1967, **2**, 107.
3 Melehov, D. E., *Social Psychiatry*, 1968, **3**, 14.
4 Kabanov, M. M., and Volovik, V. M. (Eds.), "Rehabilitation of the Mentally Ill" in *Soviet Neurology and Psychiatry*, Vol. 5. New York, International Arts and Sciences Press, 1973.
5 Melehov, D. E., Grossman, A. V., and Petrunek, V. P., *Social Psychiatry*, 1970, **5**, 12.
6 National Institute of Mental Health, *The First U.S. Mission in Mental Health to the U.S.S.R.* Washington, U.S. Government Printing Office, 1969.
7 *International Pilot Study of Schizophrenia.* Geneva, World Health Organization, 1973.
8 Zharikov, N. M., *Social Psychiatry*, 1968, **3**, 135.
9 Wing, J. K., *Schizophrenia—Medical and Social Models.* In press.
10 Wing, J. K., *The Psychiatry of Political Dissent.* In press.
11 *A Chronicle of Human Rights in the U.S.S.R.*, Nos. 1-3. New York, Khronika Press, 1973.
12 Reddaway, P., *Uncensored Russia: The Human Rights Movement in the Soviet Union.* London, Cape, 1972.

For Debate

A Randomized Controlled Trial of Acetyl Salicylic Acid in the Secondary Prevention of Mortality from Myocardial Infarction

P. C. ELWOOD, A. L. COCHRANE, M. L. BURR, P. M. SWEETNAM, G. WILLIAMS, E. WELSBY, S. J. HUGHES, R. RENTON

British Medical Journal, 1974, 1, 436-440

Summary

The results of a randomized controlled trial of a single daily dose of acetyl salicylic acid (aspirin) in the prevention of re-infarction in 1,239 men who had had a recent myocardial infarct were statistically inconclusive. Nevertheless, they showed a reduction in total mortality of 12% at six months and 25% at twelve months after admission to the trial. Further trials are urgently required to establish whether or not this effect is real.

Members of M.R.C. Epidemiology Unit, Cardiff
P. C. ELWOOD, M.D., D.P.H.
A. L. COCHRANE, M.B., F.R.C.P.
M. L. BURR, M.B., D.OBST.R.C.O.G.
P. M. SWEETMAN, M.SC.
G. WILLIAMS, S.R.N., S.C.M.
E. WELSBY, S.R.N.
S. J. HUGHES

Nicholas Research Institute, Slough
R. RENTON, M.B., D.I.H., Medical Director

Introduction

A definite and prolonged inhibition of platelet aggregation by acetyl salicylic acid (aspirin) has been shown by several workers,[1-3] and confirmed subsequently. It has repeatedly been suggested that because of this effect aspirin is likely to have a prophylactic effect in thromboembolic conditions, particularly in coronary artery thrombosis. Clinical evidence of such an effect is conflicting and clearly direct evidence of benefit can come only from randomized controlled trials. This paper reports such a trial of aspirin in the preven-